

Minutes of the meeting of the Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System held Tuesday, January 17, 2012 at the hour of 9:30 A.M., at 1900 West Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Muñoz called the meeting to order.

Present: Chairman Luis Muñoz, MD, MPH and Directors Benn Greenspan, PhD, MPH, FACHE and Heather O'Donnell, JD, LLM (3)

Board Chairman Warren L. Batts (Ex-Officio Member) and Director Hon. Jerry Butler

Absent: None (0)

Additional attendees and/or presenters were:

Cathy Bodnar – System Chief Compliance Officer
Helen Haynes – System Associate General Counsel
Jeff Kitchen – McGladrey & Pullen, LLP
Ram Raju, MD, MBA, FACS, FACHE – Chief Executive Officer

Elizabeth Reidy – System General Counsel
Deborah Santana – Secretary to the Board
Thomas Schroeder – System Director of Internal Audit

II. Public Speakers

Chairman Muñoz asked the Secretary to call upon the registered speakers.

The Secretary responded that there were none.

III. Report from System Corporate Compliance Officer (Attachment #1)

A. Activity Report

Cathy Bodnar, System Corporate Compliance Officer, presented the Annual Report of the Office of Corporate Compliance. Also presented was the Activity Report and projected Work Plan for FY2012. The Committee reviewed and discussed the information.

Ms. Bodnar informed the Committee of a current Compliance issue, involving an individual identification information breach that recently occurred. The System's Human Resources Department received a request from a County department/agency for copies of dual employment forms on file for physicians. A box containing copies of these forms was to be shipped from the System's Human Resources Department to the downtown County Building; however, this box was not delivered, and was lost. Some of the dual employment forms contained the physicians' Social Security numbers. As a result of this incident, the System has provided one year of credit monitoring for each of the physicians whose forms contained their Social Security number; for those physicians whose form did not contain their Social Security number, information was provided regarding how to set up a fraud alert warning within their credit account.

Chairman Muñoz inquired regarding the timeline for electronic Compliance training for employees. Ms. Bodnar stated that it is planned to be rolled-out in the first quarter of 2012. She expects that the roll-out to the population should be completed by February; it should be up and running no later than June 2012. In response to Chairman Muñoz' inquiry regarding the ramifications for those employees who do not comply with the Compliance training, Ms. Bodnar stated that a policy is needed to address that issue.

III. Report from System Corporate Compliance Officer (continued)

Director Greenspan, seconded by Director O'Donnell, moved to receive and file the Annual Report of the Office of Corporate Compliance. THE MOTION CARRIED UNANIMOUSLY.

IV. **Report from System Director of Internal Audit (Attachment #1)

A. Activity Report

Tom Schroeder, System Director of Internal Audit, provided a report on the following subjects: 2011 Internal Audit Accomplishments; and review of Internal Audit's Charter. The Committee reviewed and discussed the information.

Mr. Schroeder noted that the Internal Audit Charter was approved and adopted in March 2010. The Charter should be reviewed periodically and revised as needed; it is then signed-off by the Chair of the Committee, Chief Executive Officer and the Director of Internal Audit. Mr. Schroeder did not recommend any revisions to the Charter at this time; he stated that he would forward the Charter to the respective parties for their signature.

V. Recommendations, Discussion/Information Item

A. Update from RSM McGladrey & Pullen, LLP on FY2011 Audit activities

Jeff Kitchen, Partner at McGladrey & Pullen, LLP, provided an update on FY2011 Audit activities. He stated that the kick-off meeting for the Health portion of the Audit is planned for this Thursday. The plan is to kick-off internal control-related testing and reviews in early February, and to begin the audit of substantive account balances in mid to late February; that work will continue on through the end of March. The objective is to have a very solid draft of the Health System financial statements by mid-April, in order to reach the County's goal of having FY2011 County-wide audited financial statements issued by the end of May 2012.

Dr. Ram Raju, Chief Executive Officer, referenced consultant services that had been provided to the System in the recent past by the staff of RSM McGladrey; he requested that the McGladrey staff responsible for the audit work be independent from and not include those McGladrey staff who were previously involved in the consultant work.

VI. Action Items

A. Minutes of the Audit and Compliance Committee Meeting, November 29, 2011

Director O'Donnell, seconded by Director Greenspan, moved to accept the minutes of the Audit and Compliance Committee Meeting of November 29, 2011. THE MOTION CARRIED UNANIMOUSLY.

B. Any items listed under Sections V, VI and VII

VII. Closed Session Discussion/Information Items

A. **Report from System Director of Internal Audit

B. Discussion of Personnel Matters

Director Greenspan, seconded by Chairman Muñoz, moved to recess the regular session and convene into closed session, pursuant to the following exception to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(1), regarding “the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity,” and 5 ILCS 120/2(c)(28), regarding “meetings between internal or external auditors and governmental audit committees, finance committees, and their equivalents, when the discussion involves internal control weaknesses, identification of potential fraud risk areas, known or suspected frauds, and fraud interviews conducted in accordance with generally accepted auditing standards of the United States of America.” THE MOTION CARRIED UNANIMOUSLY.

Chairman Muñoz declared that the closed session was adjourned. The Committee reconvened into regular session.

VIII. Adjourn

As the agenda was exhausted, Chairman Muñoz declared the meeting ADJOURNED.

Respectfully submitted,
Audit and Compliance Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Luis Muñoz, MD, MPH, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

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January 17, 2012

ATTACHMENT #1

Corporate Compliance Office



Annual Report – FY 2011
December 2010 – November 2011

January 10, 2012

Cook County Health & Hospitals System
Corporate Compliance Office
ANNUAL REPORT – FY 2011

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Corporate Compliance Office
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I. Introduction

In Fiscal Year (FY) 2009, Cook County Health & Hospitals System (CCHHS) re-established the Corporate Compliance Office. The motivation for creating this office was to bring a System perspective to Compliance related activities. Cathy Bodnar, MS, RN, CHC was appointed the Chief Compliance Officer in September, 2009.

This Annual Report presents the activities of the second year of the System Corporate Compliance Office and demonstrates the effectiveness of our program by looking at the infrastructure, communication strategy, and evaluating the program using the seven (7) Compliance Program Elements of a comprehensive compliance program delineated by the Office of Inspector General (OIG) in 1998.

CCHHS has established a Mission, "To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies which promote and protect the physical, mental and social well being of the people of Cook County."

The Corporate Compliance Office supports the CCHHS' Mission with a departmental Mission:

To uphold the mission, vision, and core goals of Cook County Health & Hospitals System (CCHHS) by establishing and supporting a system-wide culture of honesty and respect to guide everyone's actions by

- Developing standards
- Increasing awareness
- Promoting honest behavior and professional responsibility

through education, awareness, and shared accountability that promotes compliance with applicable laws, regulations, and System policies.

CCHHS has established a Vision, "In support of its public health mission, CCHHS will be recognized locally, regionally, and nationally – and by patients and employees – as a progressively evolving model for an accessible, integrated, patient-centered, and fiscally-responsible healthcare system focused on assuring high-quality care and improving the health of the residents of Cook County."

To support CCHHS' Vision, the Vision of the Corporate Compliance Office is:

To ensure safeguards are in place for our patients, our staff, and the public at large, the Corporate Compliance Program will be a resource to everyone affiliated with Cook County Health & Hospitals System.

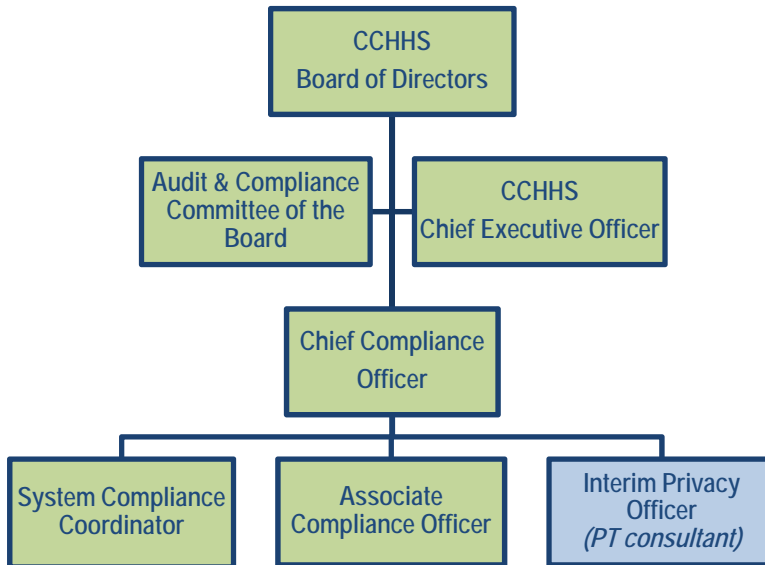
(For the purposes of this statement, "affiliated" is defined as all employees, medical staff, house staff, Board members, volunteers, students, patients, partners, consultants, agency personnel, and vendors.)

II. Building Blocks – Setting Infrastructure

The Annual Report begins with a look at the activities of the Program that comprise our efforts to establish an infrastructure to deliver a comprehensive compliance program. As noted earlier, the System Compliance Program was established in 2009 with the hiring of a Chief Compliance Officer. The Program added a Compliance Coordinator in February, 2010 and an Associate Compliance Officer in September, 2010. Attempts to hire a System Privacy Officer were conducted throughout FY10 and into FY11. A qualified candidate was selected early in FY11, unfortunately the candidate subsequently declined the appointment. At that point an external recruiter was engaged. Recruitment activities ceased in early summer 2011, when qualified candidates were not forthcoming. Critical examination of the functionality of Corporate Compliance operations, reviewing both the internal and external

environment and the candidate market, has occurred. Modifications to the existing departmental structure are being considered.

Current Compliance Organization Chart



Corporate Compliance Program Scope

The CCHHS activities that fall into the Corporate Compliance Scope were established as:

- Accurate Books and Records
- Anti-kickback
- Conflict of Interest
- Emergency Medical Treatment and Labor Act (EMTALA)
- False Claims
- Healthcare Fraud and Abuse
- Marketing and Purchasing
- Patient Privacy, Confidentiality, and Security (HIPAA)
- Political Activity (including Shakman Compliance)
- Research
- Theft

III. Being Present – Communication – Fostering Transparency

A. Communication Strategy

Developed an organizational communication strategy to increase employee awareness of the following topics:

- Definition and scope of compliance;
- Staff conduct (Standards of Conduct);
- Compliance toll-free hot line awareness;
- Responsibility to report potential/actual issues;

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- Consequences of not reporting;
- Non-retaliation process;
- Accessibility of the Compliance Officer and Program; and
- Privacy, Confidentiality, and Security.

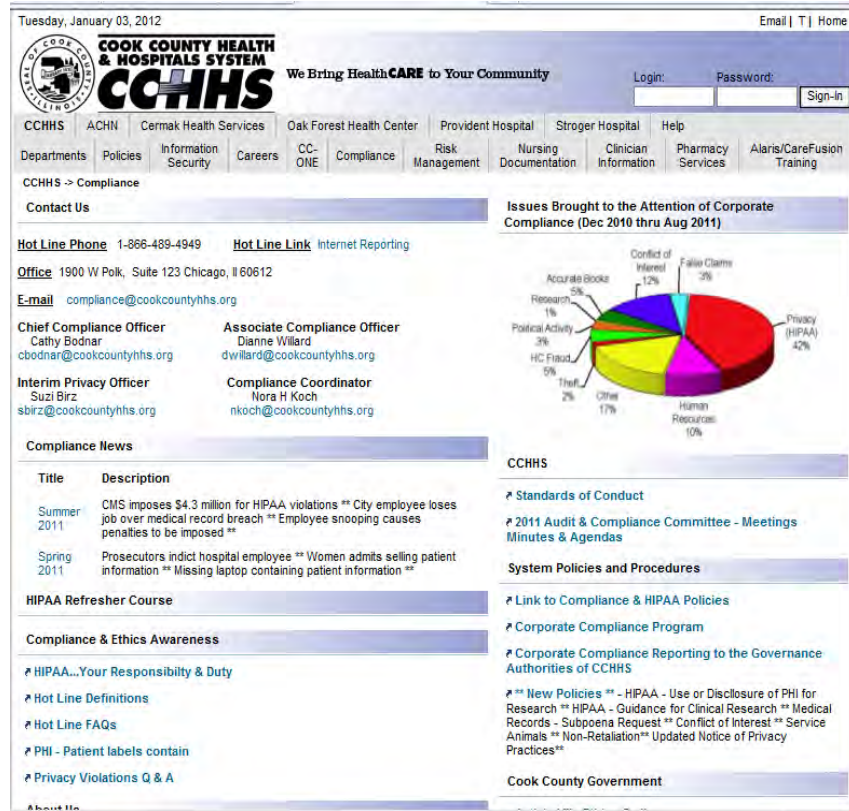
B. Communication Channels

Communicated about general corporate compliance information, toll-free hot line, HIPAA Protected Health Information (PHI), HIPAA privacy and security, HIPAA sanctions, political activity prohibitions, and Shakman compliance in multiple formats:

- Posters;
- Flyers;
- Payroll inserts;
- Compliance Program business cards;
- Pens with the compliance hot line number;
- Privacy Protector wrist bands;
- Compliance Program magnets;
- Attendance/presence at team meetings; and
- Continual update of Compliance Intranet site.

C. Corporate Compliance Intranet Site

Optimized intranet webpage to ensure employees and physicians have easy access to guidance and tools.



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The content of the compliance intranet page continues to evolve with the goal to promote transparency. The page includes the information that follows:

- Contact Information;
- Compliance News Nationally;
- Compliance and Ethics Awareness Documentation;
- Audit and Compliance Committee Meetings – Agenda and Minutes;
- Links to System Policies and Procedures;
- Cook County Government Documentation and Forms; and
- Graphic Illustrating Issues Brought to the Attention of Corporate Compliance.

D. Focused Efforts

Throughout FY11, Corporate Compliance provided support and subject matter expertise for various compliance issues to many departments and affiliates. The list that follows identifies a number of specific areas:

- | | |
|---------------------------------|----------------------------------|
| ▪ CCHHS Board of Directors | ▪ Internal Audit |
| ▪ Senior Leadership | ▪ Finance |
| ▪ Operational Leadership | ▪ Emergency Department |
| ▪ Office of the General Counsel | ▪ Interventional Radiology |
| ▪ Health Information Management | ▪ Marketing and Public Relations |
| ▪ Human Resources | ▪ Pastoral Care Services |
| ▪ Information Services | ▪ Volunteer Services |

IV. Compliance Program Structure: Our Performance of the Elements
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Element 1

The development and distribution of written standards of conduct, as well as written policies and procedures that promote the hospital's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other healthcare professionals.

A. Policies and Procedures

1. Developed and Implemented System Policies

Progress continued on drafting and vetting System policies related to compliance with governance, HIPAA, conflict of interest, and general Compliance. The following policies were approved in FY11:

- 00.01.00 Policy Management
- 01.02.40 Privacy Management
- 00.02.00 Conflict of Interest
- 01.02.10 Sending and Receiving Faxes
- 01.02.16 HIPAA: Requesting Alternative Communications
- 01.02.18 HIPAA: Use or Disclosure of PHI for Research
- 01.02.20 Social Media: Workforce Use and Conduct
- 01.02.21 Medical Records: Subpoena Request

01.02.45 HIPAA: Business Associates

01.02.55 HIPAA: Definitions

01.03.40 Reporting and Non-Retaliation

In response to amendments in HIPAA as a result of the HITECH Act, the CCHHS Notice of Privacy Practices was updated. New Notices are available to our patients in hard copy at our facilities, on our website, and within the 1st Quarter FY 2012, new Notice of Privacy Practices posters will be replaced throughout the System.

2. Work Plan Activities – Ensuring Compliance with Policies and Procedures

In FY11, Corporate Compliance worked with operational areas to assess compliance with our procedures and, in certain instances, assist in the development of new policies.

- Sanction Screening Checks

Addressed regulatory requirements to avoid employing, engaging, contracting or agreeing with any individual or entity who is excluded or “sanctioned” from participation in a federal healthcare program or who is debarred from participation in federal procurement or non-procurement programs for the provision of goods or services. This is an ongoing project for both CCHHS employees and vendors initiated in early FY10.

- Business Associate Agreements

Updated Business Associate Agreements in compliance with both the HIPAA Privacy and Security Rules and amended in the Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery and Reinvestment Act. All active CCHHS vendors classified as Business Associates were required to endorse the updated Business Associate Agreement.

- Information System Security Plan Review

Provided input into a global, system-wide information security plan developed internally by CCHHS’ Information Security Officer, the plan uses government guidance as a foundation. It incorporates the three (3) essential elements: operational, technical, and managerial to ensure the confidentiality, integrity, and availability of healthcare and patient data.

- Proactive Coding Review – Radiology Procedures

Performed a review of documentation and independently assigned codes, compared the codes assigned to the documentation, and identified variances. Determined documentation does exist; additional detailed documentation is needed to improve coding specificity. Communicated findings to the providers within the operational area; operations subsequently, requested a follow up review.

- Proactive Coding Review – Chemotherapy

Partnered with Internal Audit to provide coding compliance expertise. Performed a review of documentation and independently assigned codes, compared the codes assigned to the documentation, and identified variances. Determined documentation does exist; process improvement needed for uniform, detailed, timely documentation to meet the coding/billing requirements. In the sample reviewed, coding performed by coders in Health Information Management (HIM) paralleled Corporate Compliance coding. Challenges exist with

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medication coding which is not assigned by HIM. Finance aware of the challenges and revisions to the workflow are in process.

- Unlawful Political Activity (Shakman)
Transitioned incident reporting from CCHHS Corporate Compliance to Cook County's Office of the Independent Inspector General. The transition was part of a county-wide effort to systematize Unlawful Political Discrimination (UPD). This transition factors into the effort to sunset the Compliance Administrator. Directly involved in the dissemination of communications to support this effort and provided system-wide education.
- Record Retention
Drafted System Record Retention Policy using individual policies throughout the System and the parameters set forth by the Illinois Local Records Act. The critical element of the policy is the actual retention matrix which will supplement the policy and provide retention guidance to the System. Using the Illinois Hospital Association's Record Retention Reference and the current retention material filed with the state of Illinois, an authoritative source document is in development.
- Patient's Bill of Rights and Responsibilities
Merged key elements from Patient's Bill of Rights and Responsibilities documents found within individual business units to develop a uniform, system-wide, patient-centered document. The end product was reviewed in accordance with regulatory guidance to ensure compliance. Provided content to Marketing and Public Relations team for brochure and signage development.
- Service Animals
Developed a uniform, system-wide, patient-centered policy. Incorporated updated regulatory guidance and key elements from policies found throughout the organization. Provided language to Marketing and Public Relations team for signage development.
- Standards of Conduct
Drafted an updated Standards of Conduct that incorporated Cook County's Ethics Ordinance. The elements of the CCHHS Code meets or exceeds the Ethics Ordinance elements. At present, engaging stakeholders to provide input into the document.

Element 2

The designation of a Chief Compliance Officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who reports directly to the CEO and the governing body.

B. Compliance Office and Committees

Cathy Bodnar, the Chief Compliance Officer, reports to both the CCHHS Board Audit & Compliance Committee and the CCHHS Chief Executive Officer. In turn, the CCHHS Board Audit & Compliance Committee and the CCHHS Chief Executive Officer each report to the CCHHS Board of Directors.



The primary duties of the **Chief Compliance Officer** were established to include the following:

- Serving as an internal consultant and resource for compliance matters;
- Overseeing and monitoring the ongoing functions of the Corporate Compliance Program;
- Participating in regular, CCHHS-wide risk assessments to understand potential vulnerabilities;
- Serving as the Privacy Officer for CCHHS to assure compliance with HIPAA regarding protection of patient health information;
- Reporting on a regular basis to the CCHHS governing bodies;
- Periodically revising the Corporate Compliance Program, with input from the Audit & Compliance Committee of the Board of Directors and Executive Management in light of changes directed to the needs of CCHHS and the laws and policies of federal, state, and county bodies;
- Developing, coordinating and participating in training programs that focus on the elements of the Corporate Compliance Program and providing training such that workforce members are knowledgeable of and comply with the Standards of Conduct, compliance policies, laws and regulations;
- Coordinating and overseeing compliance auditing and monitoring activities;
- Responding to reports of issues or suspected violations related to compliance by independently investigating these matters, as appropriate, and working with department managers, Human Resources, and General Counsel in the determination of corrective action that must be taken;
- Assuring, through consultation with Human Resources and General Counsel, that the CCHHS disciplinary policies and actions are applied fairly, equitably, appropriately, and consistently; and
- Developing policies and programs that encourage CCHHS personnel to report suspected fraud and other improprieties without fear of retaliation or retribution.

The **Audit & Compliance Committee of the Board of Directors** advises the Board regarding the implementation of standards and processes to assure professional responsibility and honest behavior, compliance with regulatory requirements, and risk management.

An **Audit & Compliance Steering Committee** was established late in FY10. The primary objectives and responsibilities of this internal group of organizational leaders are to:

- Provide guidance to the corporate compliance and internal audit programs by promoting and supporting a culture of professional responsibility, honesty, and respect;
- Assist in the strategic direction of the organization with regard to compliance and internal audit matters;
- Provide advice and guidance to the Chief Compliance Officer and the System Director of Internal Audit in the accomplishment of his/her duties;
- Monitor the effectiveness of the corporate compliance and internal audit programs;
- Assist the Chief Compliance Officer and the System Director of Internal Audit in analyzing the healthcare industry compliance, financial, legal and risk environment and developing policies, procedures and systems to ensure compliance with applicable laws, regulations and guidelines;
- Review the System's annual corporate compliance and internal audit work plans;
- Review issues, concerns and trends identified internally and externally, in particular those identified as presenting a significant risk to the organization;
- Recommend to the Chief Compliance Officer and System Director of Internal Audit and the Audit and Compliance Committee and the Board, as appropriate, actions or measures that it deems appropriate to improve the effectiveness of the corporate compliance and internal audit program;
- Carry out other duties that the Audit and Compliance Committee or the Board may delegate to the Committees; and
- Review and reassess this Charter every two years or more frequently as circumstances warrant, to ensure it remains relevant to the overall purpose of the Committee.

The **Ad Hoc Work Group on Corporate Compliance** was charged with providing direction to the System Compliance Program.

Responsibilities include providing oversight on unrestricted compliance program activities; this includes, but is not limited to, guidance on the mission and vision of the compliance program, the Standards of Conduct, compliance communications, and education and training for the community in general along with CCHHS personnel.

The Group consisted of both internal and external members. The Group did not meet as a whole within FY 2011. The inactivity now triggers an evaluation of its ongoing existence. The Audit and Compliance Steering Committee is comprised of internal leaders. Therefore consideration should be given to the assembly of external leaders to provide an additional form of a check and balance.

In addition to the committee relationships:

- A formal cooperative collaboration agreement between the CCHHS Office of Corporate Compliance and the County's Office of the Independent Inspector General (OIIG) was implemented in FY11. This partnership provides investigative support to Corporate Compliance.

Element 3

The development and implementation of regular, effective education and training programs for all affected employees.

C. Education and Training

1. New Employee Orientation

- Presented an "Introduction to Corporate Compliance and HIPAA", at over twenty (20) New Employee Orientation sessions and five (5) Volunteer Sessions.
- Separately trained new resident and fellows on Corporate Compliance and Privacy. Developed on-line material to provide more detailed Compliance and Privacy education which included a review of Standards of Conduct, and an electronic attestation to follow our policies, procedures, and compliance with our Standards.

2. Targeted Education

Provided audience specific education based on identified risks as follows:

- Provided specialty HIPAA education to operational areas:
 - ✓ Cook County Department of Public Health
 - ✓ Human Resources
 - ✓ Revenue Cycle
 - ✓ JHSH Patient Relations
 - ✓ CCHHS Providers at Oak Forest Hospital
 - ✓ Department of Psychiatry
- Sent a broadcast message in partnership with Risk Management regarding the use of e-mail for transmitting Protected Health Information to all users of the CCHHS voice mail system.
- Provided training on Unlawful Political Discrimination to department directors and providers throughout the System.

3. Unlawful Political Discrimination (UPD)

Presented county-wide UPD training to organizational leadership and disseminated a county-wide log to further the goal of eliminating unlawful political discrimination in government and to foster a transparent, honest and fair employment process.

4. Interim Annual Compliance Education

Developed the content for a computer-based training module for Compliance and Privacy. Challenges presented with tracking and reporting. The training will be updated and migrated to a new electronic learning platform within FY12.

5. Computer-Based Training

Issued an RFP, selected and contracted with a vendor to provide content for Compliance and Privacy training. The product has a platform to not only house the Compliance and Privacy content but also to house any CCHHS content. Once implemented, system-wide organizational training will be managed in one central repository.

At the close of FY11, the following activities were completed to position CCHHS for a launch of computer-based training in 1st Quarter FY 2012.

- Identified the human resources data requirements,
- Determined first modules to be deployed,
- Determined additional subjects/departments to roll-out computer-based training, and
- Customized courses to meet CCHHS Compliance and Privacy needs.

Element 4

The maintenance of a process, such as a hot line, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.

D. Effective Lines of Communication – Receiving and Responding to Complaints

1. Infrastructure Activities

- a. Assisted our patients, employees, and physicians, by retaining the following mechanisms for contacting Corporate Compliance through
 - A toll-free hot line telephone number answered by a third party to preserve anonymity if desired. The caller is given a code number related to the matter, and can call back or check the website using that code number to review comments and updates.
 - A separate toll-free telephone number for privacy breaches.
 - Two (2) e-mail addresses for Compliance (compliance@cookcountyhhs.org) and Privacy (privacy@cookcountyhhs.org).
- b. Established relationships and engaged internal and external resources to assist with investigations throughout the CCHHS and Cook County.
- c. Identified trends and patterns to mitigate organizational risks.
- d. Presented trends and patterns to the Audit and Compliance Committee of the Board.

2. Process for Responding to Issues and Complaints

Retained process for issue, complaint management, and resolution as follows:

- a. Investigate the allegation and confirm the details,
- b. Determine the area affected,
- c. Collaborate with appropriate departments,
- d. Review and follow organizational policy, federal, state, and county regulations related to the incident for mitigation and remediation. These may include further auditing of documentation, sending a notification and apology letter to the patient, notifying the Centers for Medicare and Medicaid (CMS), notifying the media, and, mitigating harm to the patient (to the extent possible),
- e. Determine and execute a corrective action plan, and
- f. Respond to the complainant.

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3. Responding to Complaints from the US Department of Health and Human Services Office for Civil Rights (OCR)

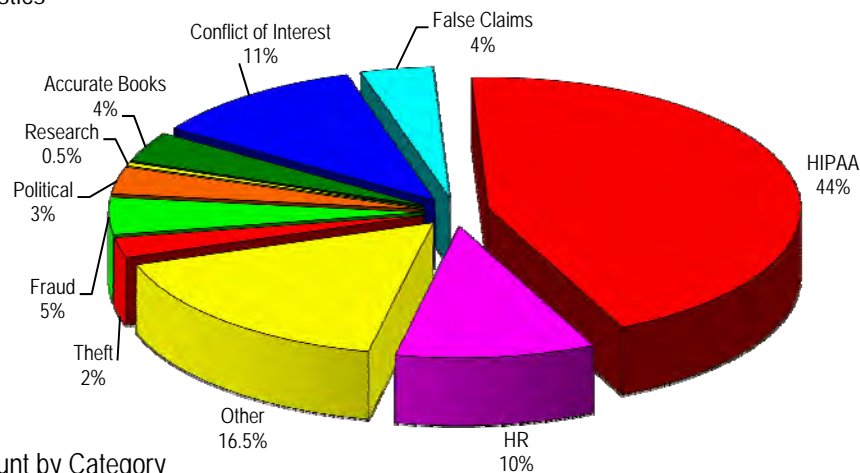
Received two (2) complaints from OCR in FY11; each complaint alleged unauthorized disclosure of Protected Health Information. Corporate Compliance conducted detailed investigations for each complaint. For one of the complaints, it is the CCHHS position that the disclosure was permitted under HIPAA and for the other, confirmed that an unauthorized disclosure did occur. In this instance, mitigation to remediate the situation occurred.

4. Reporting

Issue categories have been identified to allow the Program to most accurately measure compliance with the Standards of Conduct.

- Accurate Books and Records
- Conflict of Interest
- False Claims
- Healthcare Fraud and Abuse
- HIPAA Privacy, Confidentiality and Security
- Human Resources
- Political Activity
- Research
- Theft

5. FY11 Statistics

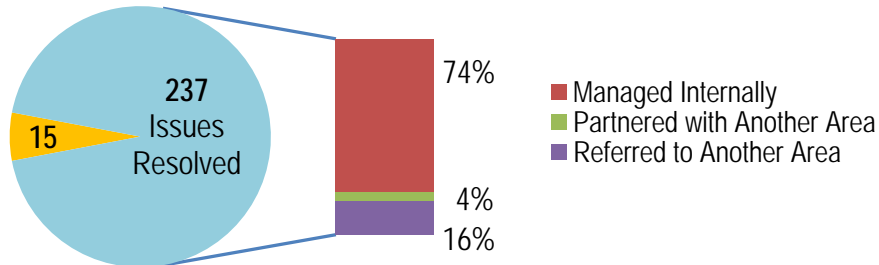


FY11 Issue Count by Category

Privacy (HIPAA)	106	Healthcare Fraud	11	Political Activity	8	Other	40
Conflict of Interest	27	Accurate Books	9	Theft	6		
Human Resources	25	False Claims	9	Research	1		

At the start of FY11, 10 issues remained active or in process from FY 2010. Therefore, a total of 252 issues were active within FY11. At 44%, Privacy (HIPAA) was the largest reactive issue category in FY11. There were 20 confirmed breaches. The breaches resulted in approximately 32,400 patient notifications. The majority, over 32,000, were a result of a breach by a Business Associate.

Of the 252 active issues, 237 or 94% were resolved. Of the 237 resolved issues, 16% or 40 issues were referred for follow-up and management outside Corporate Compliance.



Element 5

The development of a system to respond to allegations of improper/ illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements.

E. Enforcing Standards

Broadened the scope of Standards enforcement through:

1. **Information System Security Policies.** Provided guidance and insights to the newly appointed Information Services Officer (ISO). Addressed regulatory requirements to the safeguarding of electronic Protected Health Information (ePHI). Reviewed Information System Security Handbooks along with an updated Security Standards/Rules of Behavior.
2. **Business Associate Agreements.** Compliance contacted all current vendors that qualify as Business Associates under HIPAA and HITECH and requested execution of an updated Business Associate Agreement.
3. **Conflict of Interest.** Provided guidance and developed Conflict Management Plans to preserve the integrity of the decision-making process.
4. **Breach Notification.** Responsible for the investigation of all instances of lost or stolen patient information, including paper and electronic. For all instances in which the data loss constitutes a breach as defined by the Breach Notification for Unsecured Protected Health Information; Interim Final Rule, the breach notification requirements to the patient, the Secretary of HHS, and the media are completed. Corrective action plans are created and executed to improve the processes and counsel the physicians and employees involved.
5. **Investigations Resulting in Employee Related Corrective Actions.** HIPAA and Conflict of Interest complaints were investigated and resulted in employee guidance being provided.

Element 6

The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area.

F. Auditing and Monitoring

The Corporate Compliance Program conducted proactive coding audits using the following methodology:

1. Determine the area in need of a focused review
2. Identify the time frame and sample size
3. Conduct review
 - ✓ "Blind" review of documentation for coding accuracy based on medical record documentation to independently assign codes
 - ✓ Compare blind review to data actually coded by HIM (soft-coded) or Charge Master (hard-coded) and data billed. Compare the codes assigned to the documentation
 - ✓ Identify variances
 - ✓ Identify strengths and weaknesses in process to mitigate risk
4. Communicate the variance to the operational area(s)

Element 7

The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

G. Risk Assessment

Addressed previously identified risks and challenges to meeting the standards of an effective compliance program. Activities highlighted in this report minimized risk through the introduction and enforcement of policies and standards, proactive auditing, education, and issue investigations with corrective action plans as appropriate.

The course of activities in FY11 has led to the identification of specific risks. Some of these risks may affect our patients. The following risks were identified for further assessment in FY12:

- Securing Protected Health Information in electronic and paper format through encryption and secure storage devices.
- Training and obtaining appropriate storage of files containing Protected Health Information Transporting paper for individual and departmental use through CCHHS buildings, our educational and district partners of Rush and UIC, and off-campus.
- Managing clinical revenue for both the facility/technical component and the professional fee component.
- Assessing Pharmaceutical pricing and billing.
- Ensuring appropriate coding and billing practices as Revenue Cycle increases claim generation.

V. Looking Ahead

With a solid foundation established, the Corporate Compliance Program will focus on analysis and risk reduction related to areas of compliance, implementation of System policies and procedures, and realization of the annual compliance education plan.

These priorities have been established:

- Continue to serve as a resource to all our patients, our staff, and the public at large.
- Continue to investigate all complaints brought to the attention of the Program.
- Continue to perform proactive auditing and monitoring for healthcare services, in both professional and facility/technical areas, patient privacy and confidentiality, and policy compliance.
- Continue to develop policies to promote compliance.
- Deploy system-wide annual compliance education using an e-Learning Management System.
- Deploy system-wide conflict of interest data collection tool for annual attestation and reporting changes throughout the year.
- Implement System record retention policy and procedure.
- Publish and distribute an updated Standards of Conduct.
- Implement solutions aimed at identifying and resolving preventable risks.

Corporate Compliance Report

Cathy Bodnar, MS, RN, CHC
Chief Compliance Officer

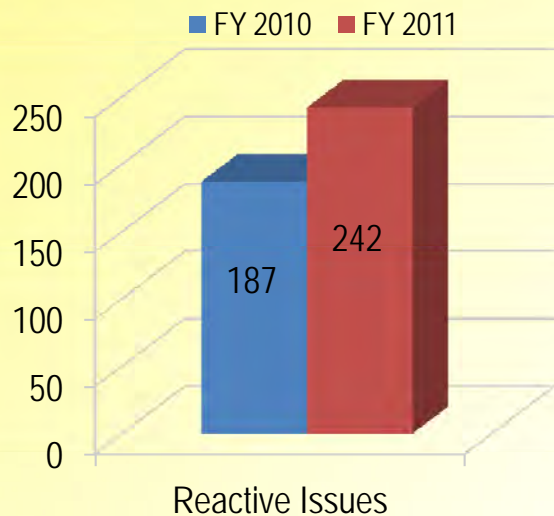
January 17, 2012



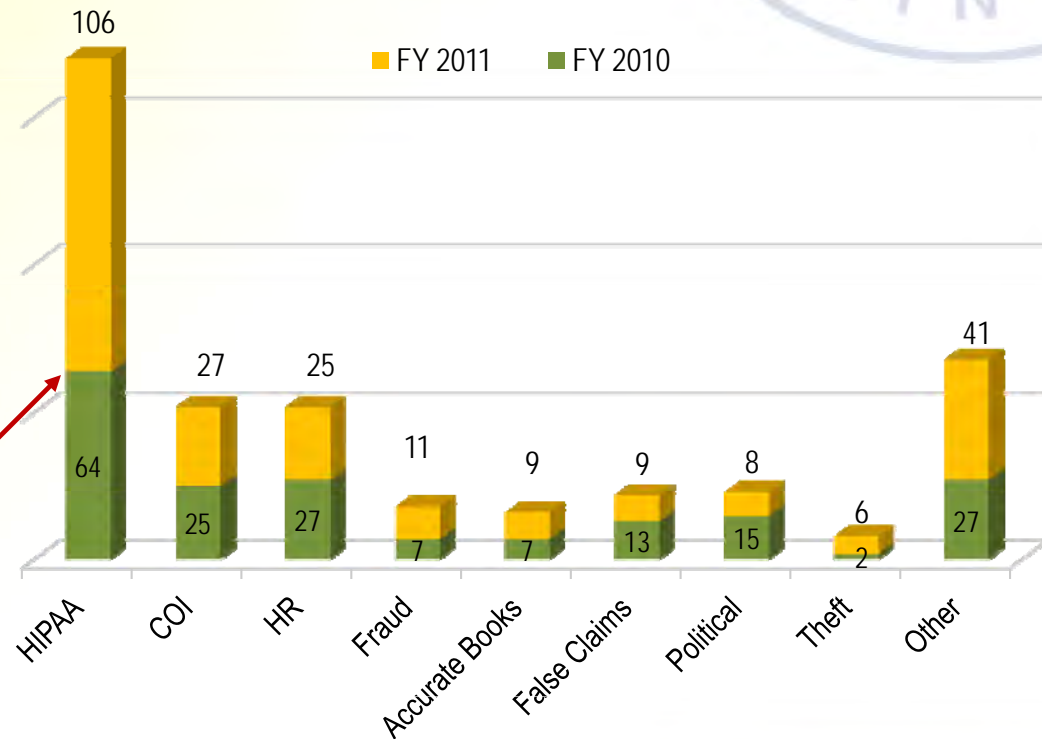
Objectives

- To file the FY 2011 Corporate Compliance Annual Report.
- To briefly discuss recent activity.
- To present the projected Work Plan for FY 2012.

FY 2011 to FY 2010 Comparison Compliance Issues (Reactive)

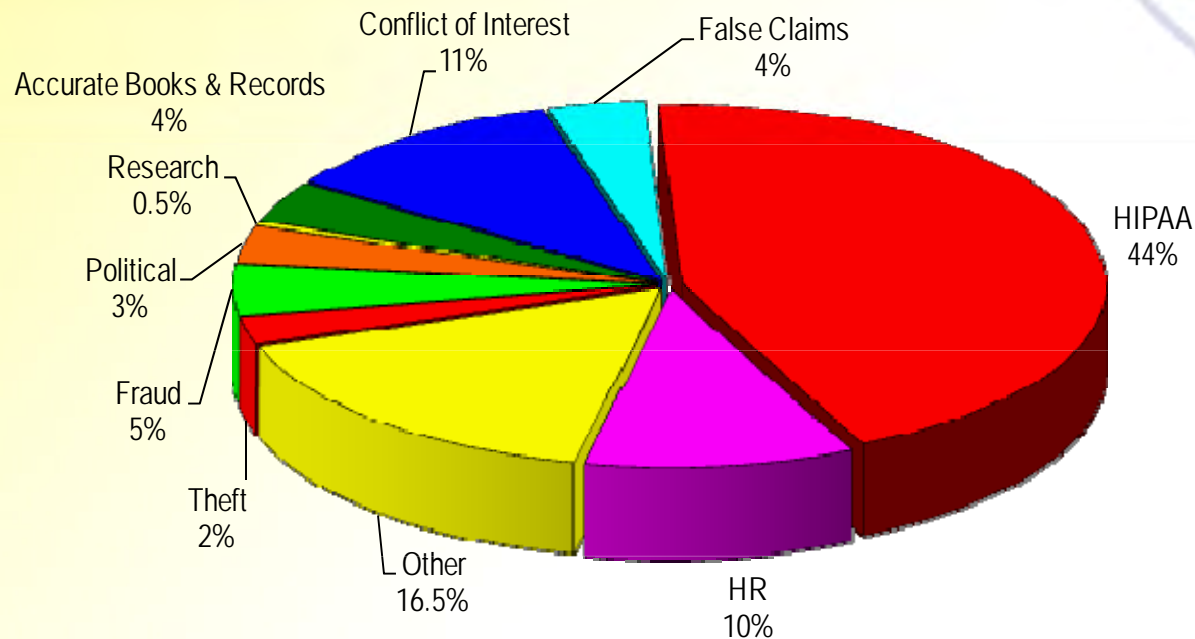


Patient Privacy, Confidentiality and Security are consistently our top issues.



Compliance Issues (Reactive)

242 Issues Opened in FY 2011



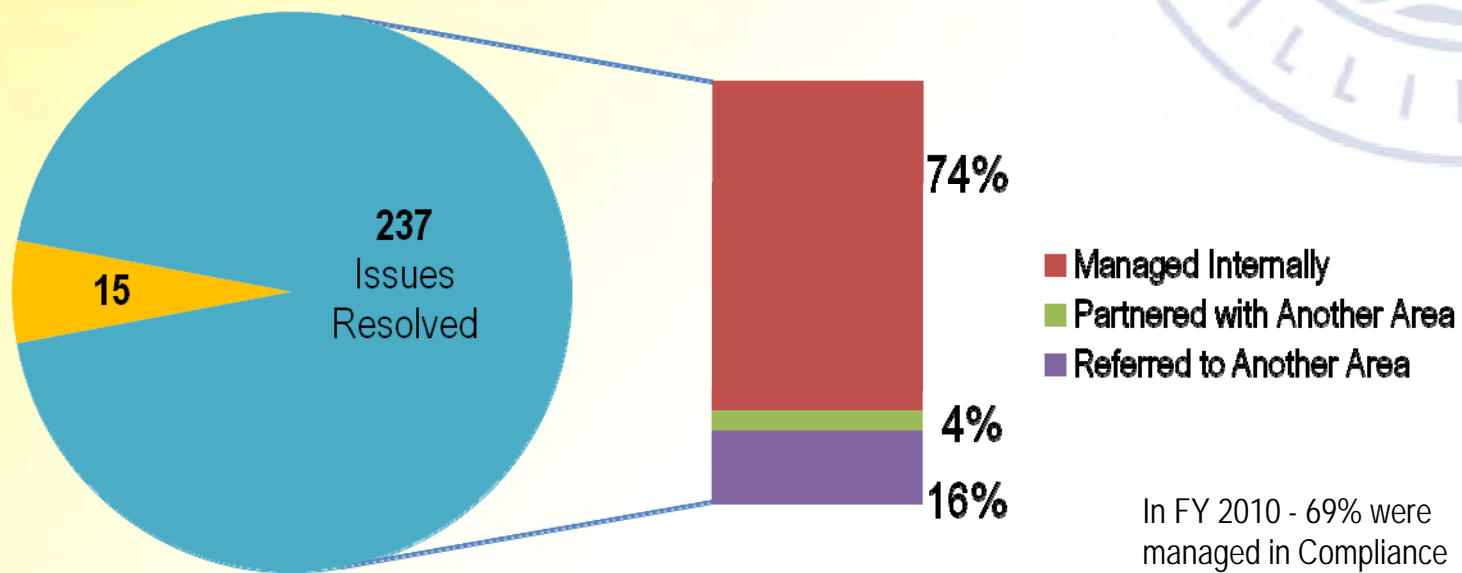
FY 2011 Issue Count by Category

Privacy (HIPAA)	106	Healthcare Fraud	11	Political Activity	8	Other	40
Conflict of Interest	27	Accurate Books	9	Theft	6		
Human Resources	25	False Claims	9	Research	1		



Total Issues

At the start of FY 2011, 10 issues remained active or in process from FY 2010. A total of 252 issues were active within FY 2011.



Of the 252 active issues, 237 of 94% were resolved.

Of the 237 resolved issues, 16% or 40 issues were referred outside of Corporate Compliance.

In FY 2010 - 69% were managed in Compliance
.....
↑ In FY 2011 - 78% were managed in Compliance





Questions?





Current Issue



Compliance Work Plan (Proactive)

FY 2012 Proposed Goals

- Continue to serve as a resource to all our patients, our staff, and the public at large.
- Continue to investigate all complaints brought to the attention of the Program.
- Continue to perform proactive auditing and monitoring for healthcare services, in both professional and facility/technical areas, patient privacy and confidentiality, and policy compliance.
- Continue to develop policies to promote compliance.
- Implement solutions aimed at identifying and resolving preventable risks.



Compliance Work Plan (Proactive)

FY 2012 Proposed Goals (continued)

- Deploy system-wide annual compliance education using an Electronic Learning Management System.
- Publish and distribute an updated Standards of Conduct.
- Deploy system-wide conflict of interest data collection tool for annual attestation and reporting changes throughout the year.
- Implement System record retention policy and procedure.



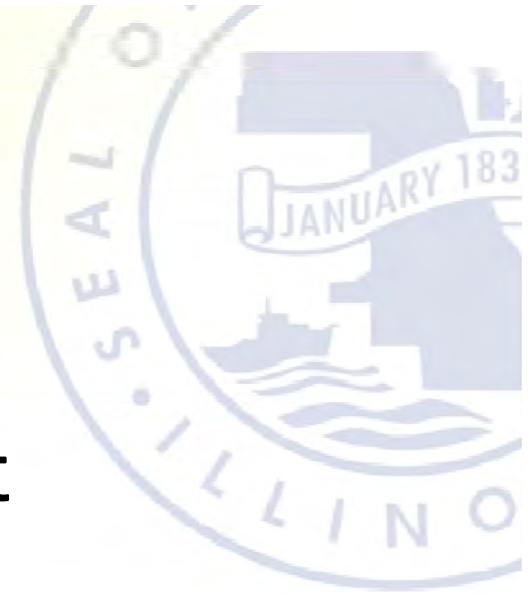


Questions?



Cook County Health and Hospitals System
Minutes of the Audit and Compliance Committee Meeting
January 17, 2012

ATTACHMENT #2



Internal Audit Report

January 17, 2012



Objective

- To review 2011 Internal Audit Accomplishments
- To review Internal Audit's Charter
- Closed Session

2011 In Review

- Completed transition to a CCHHS staffed internal audit function from an outsourced model
- Completed a risk assessment and developed a 12-18 month internal audit plan based on the risk assessment
- Substantial progress made towards completing the internal audit plan
- Other – staff development, audit directors roundtable



Internal Audit Charter

Significant Sections (complete charter included)

1. Mission
2. Role
3. Professional Standards
4. Authority
5. Independence
6. Accountability
7. Audit Scope
8. Responsibility

Cook County Health and Hospitals System (CCHHS)

Internal Audit Charter

January 17, 2012

Mission

Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

Internal Audit will align its activities with the mission and strategy of CCHHS. Internal Audit will promote good controls and serve as an educational resource to its stakeholders with respect to risk management, control and governance processes. Internal Audit will maintain a collaborative approach to its work practices and will ensure its work product provides value added outputs for its stakeholders.

Role

- Internal Audit's role is determined by the CCHHS Board of Directors through its Audit and Compliance Committee.
- Responsibilities are defined by the CCHHS Board of Directors through its Audit and Compliance Committee.

Professional Standards

- Internal Audit will govern themselves by adherence to the Institute of Internal Audit's "Code of Ethics". <http://www.theiia.org/guidance/standards-and-guidance/ippf/code-of-ethics/english/>
- The Institute's "International Professional Practice Framework" shall constitute the operating procedures for the department. These documents are considered an addendum to this Charter. <http://www.theiia.org/guidance/standards-and-guidance/ippf/standards/>
- Internal Audit will adhere to all CCHHS policies and procedures and all Internal Audit procedure manuals.

Authority

Internal Audit is authorized to:

- Have unrestricted access to all functions, records, property and personnel.
- Have free, open, and timely access to the Chief Executive Officer and the CCHHS Board of Directors through its Audit and Compliance Committee.
- Allocate department resources, set frequencies, select subjects, determine scope of work and apply the techniques required to achieve audit objectives.
- Obtain the necessary assistance of personnel in the organization when performing audits, as well as other specialized services from within or outside the organization.

Independence

- All audit activities shall remain free of influence by any element in the organization, including matters of audit scope, procedures, frequency, timing, or report content, required to permit the independence required to render objective reports.
- Internal auditors shall have no operational responsibility or authority over any activities they review.
- Internal auditors shall not develop or install systems or procedures, prepare records or engage in any other activity that they would normally audit.

- Internal Audit reports functionally to the CCHHS Board of Directors through its Audit and Compliance Committee and administratively to the Chief Executive Officer.
- Internal Audit periodically reports to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership as outlined in the section on Accountability.

Accountability

Internal Audit is accountable to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership to:

- Report significant issues related to the process for controlling the activities of the organization, including potential improvements to those processes, and provide information concerning such issues through resolution.
- Provide information periodically on the status and results of the annual audit plan and the sufficiency of internal audit resources.
- Coordinate with and provide oversight of other control and monitoring functions.

Audit Scope

The scope of the work of Internal Audit is to determine whether the network of risk management, control and governance processes, as designed and represented by management, is adequate and functioning in a manner to ensure:

- Risks are identified and managed.
- Interaction with various governance groups occurs as needed.
- Significant financial, managerial and operating information is accurate, reliable and timely.
- Employee's actions are in compliance with policies, standards, procedures and applicable laws and regulations.
- Resources are acquired economically, used efficiently, and adequately protected.
- Programs, plans and objectives are achieved.
- Quality and continuous improvement are fostered in control processes.
- Significant legislative or regulatory issues impacting the organization are recognized and addressed properly.

Responsibility

- Develop an annual audit plan using risk-based methodology, including any risk or control concerns expressed by management, and submit the plan to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership for approval.
- Implement the audit plan and any special requests by the CCHHS Board of Directors, its Audit and Compliance Committee, and CCHHS Senior Leadership and management.
- Maintain a professional audit staff capable of meeting the requirements of this Charter.
- Establish a quality assurance program whereby the director of internal audit assures the operations of internal audit.
- Perform consulting services in addition to assurance services. Consulting services are defined as "advisory and related client services activities, the nature and scope of which are agreed with the client and which are intended to add value and improve the organization's governance, risk management and control processes without the internal auditor assuming management responsibility." Examples include counsel, advice, facilitation, and training.
- Evaluate and assess significant merging/consolidating functions and new or changing services, processes, operations and control processes, coincident with their development, implementation and/or expansion.

- Issue periodic reports to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership summarizing results of internal audit activities.
- Inform the CCHHS Board of Directors through its Audit and Compliance Committee, and CCHHS Senior Leadership of emerging trends and successful practices in internal auditing.
- Provide the CCHHS Board of Directors through its Audit and Compliance Committee, and CCHHS Senior Leadership a list of internal audit measurement goals and results.
- Assist in the investigation of significant suspected fraudulent activities.
- Consider the scope of work of the external auditors and regulators for the purpose of providing optimal audit coverage at a reasonable cost.

Dr. Luis Munoz
Audit and Compliance Committee Chair

Dr. Ram Raju
Chief Executive Officer

Tom Schroeder
Director of Internal Audit